Application Completion Instructions 2006

Purpose

This chapter explains in detail how to complete the joint Healthy Families and Medi-Cal for Families mail-in application.

Mail-In Application Booklet and Handbook

The joint Healthy Families and Medi-Cal for Families mail-in application booklet includes the four-page application, basic instructions for completion, and a pre-addressed, postage-paid envelope. The application and the Healthy Families Handbook are available in the following ten languages:

- English
- Spanish
- Vietnamese
- Khmer (Cambodian)
- Hmong
- Armenian
- Chinese
- Korean
- Russian
- Farsi

The application is divided into individual sections with numbered questions. It is important that the application be completely and legibly filled out when submitted. Missing information or information which cannot be read can delay processing of the application.

Review of Applications

All mailed applications are screened by Single Point of Entry (SPE) for no-cost Medi-Cal. In certain circumstances, the county Department of Social Services may determine that the children are eligible for no-cost Medi-Cal even though they appeared to be eligible for the Healthy Families Program. It is important that CAAs explain this to families. See Chapter 4 (*Family Size and Income Determinations*) for more information.

Some examples where this could occur include the following:

- Children can have separate incomes that are counted, i.e., child support or Social Security
- Children under 18 have their own children and live with their own parents
- Stepparents or unmarried parents are part of the family size
- Pregnant teenager applying for the Healthy Families Program

In these situations, the children's natural or adoptive parents and the children's own incomes are used to determine the families' incomes. The income of stepparents, foster parents, caretaker relatives, and siblings is not used.

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MEDI-CAL FOR CHILDREN

APPLICATION

Please use the instructions to complete this application.
Print clearly. Use black or blue ink only.

HEALTHY FAMILIES

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SECTION 1: Tell us about the person applying for the child, the pregnant woman, the unborn child, or him or herself.

1 LAST NAME / FIRST NAME / MIDDLE INITIAL			2 BIRTHDATE MO / DATE / YR
3 HOME ADDRESS (NUMBER AND STREET). **DO NOT USE A P.O. BOX**		4 APARTMENT NUMBER	5 HOME PHONE # ( )
6 CITY	7 COUNTY	8 ZIP CODE	9 WORK PHONE # ( )
10 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		11 APARTMENT NUMBER	12 MESSAGE PHONE # ( )
13 CITY			14 ZIP CODE
15A WHAT LANGUAGE DO YOU SPEAK BEST?		15B WHAT LANGUAGE DO YOU READ BEST?	

16 We will enroll the child or pregnant woman in the program they qualify for. If you do not want to be enrolled in one of these programs, check the box(es) below.

I DO NOT WANT:
- ❑ Healthy Families: Do not send birth certificates. Do not complete the Healthy Families Page.
- ❑ Medi-Cal

SECTION 2: Tell us about the children under 19 and/or the pregnant woman who want health coverage.

	Child 1 or Unborn (Check box if unborn)	Child 2	Child 3	Child 4	Pregnant Woman
17 Name: Last					
First					
Middle					
18 Name on Birth Certificate: (If same as #17 above, leave blank.) Last					
First					
Middle					
19 If the child's address is not the same as in Section 1, Question 3, give complete address:					
20 Relationship to person in Section 1:					
21 Sex:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
22 Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23 Place of Birth: County or State or Country, if outside the U.S.					
24 Ethnic Code: (See #24 Instructions)					
25 U.S. Citizen or National? If "no", please write date of entry into U.S.	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR
26 Social Security #:					

Social Security Numbers are not required for Healthy Families or for persons who want emergency or pregnancy related services only.

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SECTION 2: Continued

	Child 1 or Unborn (Check box if unborn)	Child 2	Child 3	Child 4	Pregnant Woman
27 Mother's Name: Last					
First					
Does the mother live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
28 Father's Name: Last					
First					
Does the father live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
29 Name of teen's spouse or pregnant woman's husband: *(If living in the home)*					
30 Does any person(s) being applied for have no-cost Medi-Cal? If "yes", give date coverage ends/ended.	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR	❑ Yes ❑ No / / MO DAY YR
31 Does the pregnant woman and/or children have other health, dental or vision insurance?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
32 Were any of the children insured by an employer in the last 90 days? If "yes", check the main reason why health insurance stopped and give the date it stopped.	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR	❑ Yes ❑ No ❑ Lost job ❑ Moved and no insurance available ❑ Employer ended benefits to all employees ❑ COBRA coverage ended ❑ Other / / MO DAY YR

SECTION 3: Family members living in the home. Family size is taken into consideration when determining which program your children are eligible for.

33 List any other children living in the home under age 21 who are not listed in Section 2. Give their relationship to the person in Section 1, Question 1.

LAST NAME, FIRST NAME	RELATIONSHIP	LAST NAME, FIRST NAME	RELATIONSHIP
LAST NAME, FIRST NAME	RELATIONSHIP	LAST NAME, FIRST NAME	RELATIONSHIP

34 Are any family members who are living in the home pregnant? ❑ Yes ❑ No

If yes, who: ____________________ Date Due: ____________________

35 List any stepparent living in the home not already listed: ____________________
LAST NAME, FIRST NAME

36 Do any of the people listed in this Section, or any of the parents listed in Section 2, want Medi-Cal? ❑ Yes ❑ No

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SECTION 4: List the gross income (before taxes) of all persons listed in Section 2, Questions 17, 27, 28, 29 and Section 3 who live in the home. If self-employed or using federal income tax return to prove income, only complete Questions 37, 38 and 40 in this section.

37 NAME OF PERSON WITH INCOME	38 SOURCE OF INCOME?	39 HOW OFTEN RECEIVED?	40 HOW MUCH GROSS INCOME?	41 SOCIAL SECURITY # *(Optional)*
1.				
2.				
3.				
4.				

SECTION 5: Deductions from Family Income. The answers in this section will help determine what amounts will be deducted from your family's gross monthly income.

42 TYPE OF PAYMENT YOUR FAMILY MAKES	43 NAME OF PERSON WHO PAYS	44 MONTHLY AMOUNT PAID
Child Support		
Alimony		

45 CHILD CARE OR DEPENDENT CARE *(List child's name)*	46 AGE	47 MONTHLY AMOUNT PAID
1.		
2.		
3.		
4.		

SECTION 6: Other Coverage.

48 Has anyone filed a lawsuit because of an accident or injury on behalf of the pregnant woman and/or child applying for benefits? ❑ Yes ❑ No

49 Does the pregnant woman and/or child want to apply for **Medi-Cal** coverage for any medical expenses in the last 3 months? ❑ Yes ❑ No

If "yes", list month(s): _____

50 Check this box if you do not want **Medi-Cal** to share your child's application with the low-cost **Healthy Families** if your child no longer qualifies for no-cost **Medi-Cal.** ❑

SECTION 7: Voluntary Information. Not required. Your answers will not affect your eligibility but they will help the state to get additional federal money to pay for health care programs.

51 Is there more than one car in the children's household? ❑ Yes ❑ No

52 Is there more than $3,150 cash in bank accounts in the children's household? ❑ Yes ❑ No

SECTION 8: Signature and Certification.

53 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature _____ Date: _____

Witness Signature _____ Date: _____
(If person signed with a mark)

Authorized Representative *(If any)* _____ Date: _____

SECTION 9: Fill in ONLY if you have been helped by a Certified Application Assistant (CAA).

54 If you would like information released to a CAA, check this box:

❑ By checking this box and signing below, I give my permission for **Healthy Families** and **Medi-Cal** to give information over the telephone about the status of this Application to the representative of the Enrollment Entity organization identified below. This permission will end on the date the program mails the results of the eligibility determination on this Application.

55 I certify I had help completing this form by the Certified Application Assistant listed below. This CAA help was **FREE** of charge. CAA#: ❑❑❑❑❑❑❑❑ EE#: ❑❑❑❑❑

Applicant Signature: _____ Date: _____

CAA Signature: _____ Date: _____

The state will not issue a reimbursement to the enrollment entity unless this question is completely and correctly filled out at the time this Application Form is submitted.

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FOR HELP, CALL TOLL-FREE, 1-800-880-5305

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If it appears you qualify for **Healthy Families** and want to choose your health, dental and vision plan now, fill out this page. Otherwise, we will contact you later for this information. See your **Healthy Families Handbook** for more information, or visit our web site at **www.healthyfamilies.ca.gov**.

SECTION A: Health, Dental and Vision Plan Choices.

Health Plan/Code	57 Dental Plan/Code	58 Vision Plan/Code

59 Name of Doctor/Clinic *(optional)*	60 Doctor/Clinic Code *(optional)*	61 Name of Dentist/Clinic *(optional)*	62 Dentist/Clinic Code *(optional)*

SECTION B: Rural Demonstration Project.

63 If you are in any of these groups, there is a new statewide health, dental and vision plan combination offered to you. You can pick this new combination and put the code in the box below. See the **Healthy Families Handbook** for the combination code number.

Check all boxes that apply to you.

❑ Native American Indian **OR** Working in seasonal or migratory jobs: ❑ Agriculture ❑ Forestry ❑ Fishing

Plan Combination Code

SECTION C: Healthy Families Declarations

I declare that each person I am applying for:

- is a resident of California.
- is not in jail or in a mental hospital.
- is not eligible for Medicare Part A and Part B.
- is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s).

I further declare that:

- all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating plans in which the individual is enrolled.
- I have read and understand the **Healthy Families Handbook**. I understand what it says about each health, dental and vision plan and the benefits they offer.
- I am applying for all of my children eligible for **Healthy Families**, unless they are already enrolled, or I am 18 years old or a minor and applying for myself.
- I agree to pay 6 monthly premiums. If I do not pay the premiums, I will be taken off the program and cannot participate again for 6 months. I will have to pay for any **Healthy Families** services I use in the last month after coverage ended.
- I give permission to **Healthy Families** to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this application.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

SECTION D: Privacy Notice.

The Information Practices Act of 1977 and the Federal Privacy Act require the **Healthy Families** Program to provide the following notice to individuals who are asked by **Healthy Families** to supply information:
Personal and medical information requested is for subscriber identification and program administration purposes only. Program regulations under Title 10, CCR, Section 2699.6600 require that every individual furnish certain information when applying to the **Healthy Families** Program. Subscriber's information may be shared with State and local agencies involved in the administration of health programs. Information (including immigration status) about persons who do not become subscribers, will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.
The following information on the application is not mandatory: social security number, ethnicity information (unless the subscriber is a Native American Indian) and any other item marked voluntary or optional. An individual has a right to access records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is the Deputy Director of Eligibility and Enrollment, Managed Risk Medical Insurance Board, 1000 G Street, Room 450, Sacramento, California 95814, (916) 324-4695.

SECTION E: Resolving Disputes.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. The **Healthy Families Handbook** has information about each plan and the arbitration requirements. You may call the plans you choose to find out more.

SECTION F: Signature and Certification.

64 **I certify** that I have read and understand the information above. **I also certify** that the information I have given on this form is true and correct.

Signature _____ Date _____

Witness Signature _____ Date _____

(If person signed with a mark)

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FOR HELP, CALL TOLL-FREE, 1-800-880-5305

Application Page A1

Page A1 of the application requests information about the applicant who is applying for Medi-Cal or Healthy Families.

SECTION 1: Applicant's Information

The applicant is the person who is completing the application for himself or herself, a child, pregnant woman, or unborn child. The child must live with the applicant unless he/she is the natural or adoptive parent and wishes to apply only for Healthy Families for the children. See Chapter 7 (*Healthy Families Program)* for more information.

Applicants include the following people:

- Natural or adoptive parents (whether they live with the child or not)
- Caretaker relatives, such as grandparents, aunts, uncles, cousins, siblings, or other family members with whom the child lives and who exercise the primary care and control of the child
- Legal Guardians who have a court order or other legal status that gives authority for health care and other decisions. A copy of a court order does NOT need to be submitted with the application.
- Foster parents
- Stepparents
- A person applying for coverage on his or her own behalf (including a pregnant woman)
- Children under age 18 may apply for coverage on their own if they are over age 14 and are not living with a parent or caretaker relative, legal guardian, foster parent, or stepparent

NOTE: Minor parents (age 18 or younger) who have their own children may complete an application for their children. However, if minor parents live with their own parents and want coverage for themselves, their parents must apply for them.

Application Page A1

MEDI-CAL FOR CHILDREN

APPLICATION

Please use the instructions to complete this application.
Print clearly. Use black or blue ink only.

HEALTHY FAMILIES

SECTION 1: Tell us about the person applying for the child, the pregnant woman, the unborn child, or him or herself.

1 LAST NAME / FIRST NAME / MIDDLE INITIAL			2 BIRTHDATE MO / DATE / YR
3 HOME ADDRESS (NUMBER AND STREET). DO NOT USE A P.O. BOX		4 APARTMENT NUMBER	5 HOME PHONE # ( )
6 CITY	7 COUNTY	8 ZIP CODE	9 WORK PHONE # ( )
10 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		11 APARTMENT NUMBER	12 MESSAGE PHONE # ( )
13 CITY			14 ZIP CODE
15A WHAT LANGUAGE DO YOU SPEAK BEST?		15B WHAT LANGUAGE DO YOU READ BEST?	

16 We will enroll the child or pregnant woman in the program they qualify for. If you do not want to be enrolled in one of these programs, check the box(es) below.

I DO NOT WANT: ❑ Healthy Families: Do not send birth certificates. Do not complete the Healthy Families Page.
❑ Medi-Cal

Section 1: Questions

1. Applicant's Name

   - List the last name, first name, and middle initial of the applicant.

2. Applicant's Birthdate

   - Enter the birthdate of the applicant as shown: Month/Day/Year.

3. Home Address

   - Enter the street address, road, rural route, or other physical description where the applicant lives. DO NOT ENTER A P.O. BOX ADDRESS.

4. Apartment Number

   - Enter the apartment or unit number (or letter) if the applicant lives in an apartment
   - Leave blank if the applicant does not live in an apartment

5. Home Phone Number

   - Enter the applicant's home phone number including the area code
   - Leave blank if the applicant does not have a home phone number

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NOTE: Applicants should provide at least one phone number on the application so they can be contacted for clarification or when additional information is required. This could also be a work phone number or message phone number (Questions 9 and 12).

6. City

   - Enter the city in which the applicant lives.

7. County

   - Enter the county in which the applicant lives.

8. Zip Code

   - Enter the zip code in which the applicant lives.

9. Work Phone Number

   - Enter the applicant's work phone number
   - Leave blank if the applicant does not have a work phone number.

10. Mailing Address

    - Enter the applicant's mailing address if it is different from the home address provided in Question 3
    - If the applicant has a P.O. Box, list it here
    - Leave blank if the mailing address is the same as the home address

11. Apartment Number

    - Enter the apartment or unit number (or letter) if the applicant lives in an apartment
    - Leave blank if the applicant does not live in an apartment

12. Message Phone Number

    - Enter the message phone number
    - Leave blank if the applicant does not have a message phone number

13. City

    - Enter the city of the applicant's mailing address
    - Leave blank if the mailing address is the same as the home address

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14. Zip Code

- Enter the zip code of the mailing address
- Leave blank if the mailing address is the same as the home address

15. 15A Language Spoken Best

- Enter the language the applicant speaks best
- This information is used when the applicant needs to be contacted by telephone
- Call Center Representatives are available to assist in the following languages:

English	Armenian	Ukrainian
Spanish	Cantonese	Punjabi/Hindi
Vietnamese	Korean	Tagalog
Khmer (Cambodian)	Russian	Mandarin
Hmong	Farsi	

15B Language Read Best

- Enter the language the applicant reads best
- This information is used when any written correspondence needs to be sent to the applicant

16. Programs the Applicant Does Not Wish to Apply For

- Applicants can indicate the programs for which they DO NOT want to be considered. If applicants check a box, the children will NOT be screened for that program even if they qualify. For this reason, applicants are strongly encouraged to leave all boxes unchecked so the children will be evaluated for whichever program they may be eligible.

  For example: If an applicant checks the “I DO NOT WANT Medi-Cal” box and the children are screened eligible for no-cost Medi-Cal by Single Point of Entry (SPE), the application will not be forwarded to the county Department of Social Services.

  In this example the family would receive a “Reconsider Medi-Cal” letter from the Single Point of Entry stating that the children appear to be eligible for Medi-Cal. This notice also gives applicants the opportunity to provide SPE with consent to forward their application to the county Department of Social Services.

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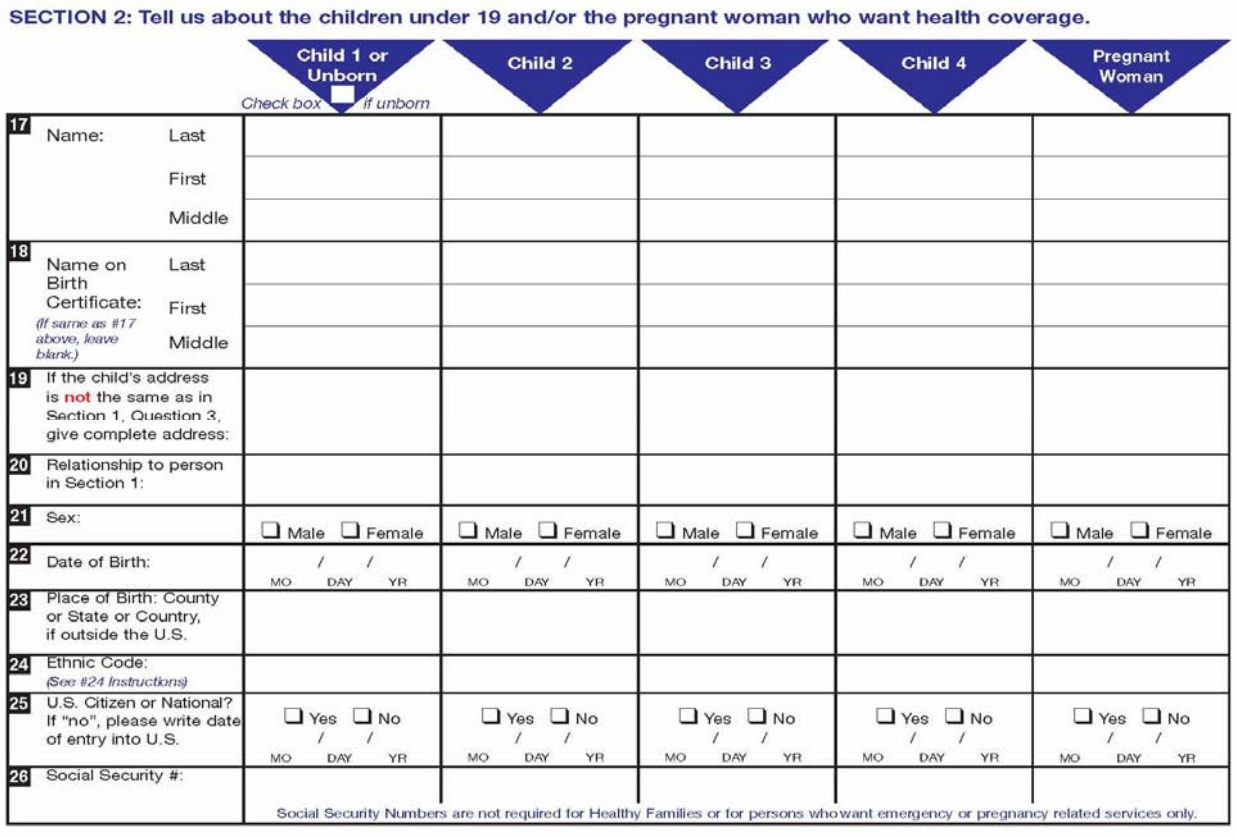
SECTION 2: Information about Children and the Pregnant Woman

This section asks for information about children under age 19, an unborn child, and/or the pregnant woman who wants health coverage.

The application has columns for four children plus a column for a pregnant woman. If the "Pregnant Woman" column is not needed, it can be used for a fifth child. Cross out the column heading and write above it "Child 5."

Applicants can also apply for Healthy Families for an unborn child up to 3 months before the child's expected due date. If the family income is too high for the pregnant woman to receive no-cost Medi-Cal but the family income is within the eligibility level for "Child Birth Up to Age 1" for the Healthy Families Program (between 200% and 250% of the Federal Income Guidelines), the unborn child may be eligible for Healthy Families Program. In this case, use the "Child 1 or Unborn" column, checking the box to indicate this is an unborn child. Complete as much information as possible in this column (including Questions 22, 27, and 28 shown on pages 8-12, 8-15 and 8-16).

Section 2: Questions



SECTION 2: Tell us about the children under 19 and/or the pregnant woman who want health coverage.

		Child 1 or Unborn (Check box ☐ if unborn)	Child 2	Child 3	Child 4	Pregnant Woman
17	Name: Last					
	First					
	Middle					
18	Name on Birth Certificate: (If same as #17 above, leave blank.) Last					
	First					
	Middle					
19	If the child's address is not the same as in Section 1, Question 3, give complete address:					
20	Relationship to person in Section 1:					
21	Sex:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
22	Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23	Place of Birth: County or State or Country, if outside the U.S.					
24	Ethnic Code: (See #24 Instructions)					
25	U.S. Citizen or National? If "no", please write date of entry into U.S.	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR
26	Social Security #:					

Social Security Numbers are not required for Healthy Families or for persons who want emergency or pregnancy related services only.

Application Page A1

Questions 17 through 32 MUST be answered for each child and/or pregnant woman requesting coverage.

Section 2: Questions

17. Name

- List the name (last, first, middle) of each child and/or pregnant woman who want health coverage
- Leave blank for an unborn child (column 1)

18. Name on Birth Certificate

- List the name exactly as it appears on each child's and/or pregnant woman's birth certificate
- Leave blank for an unborn child or if the name on the birth certificate is the same as in Question 17

19. Child's Address

- Enter the child's address if the child does not live with the applicant
- The child and/or pregnant woman must live in California to be eligible for either Medi-Cal or Healthy Families
- Leave blank for an unborn child (column 1)

20. Relationship to Person in Section 1

- List the relationship of each child and/or pregnant woman to the applicant who is listed in Section 1. This would include son, granddaughter, stepdaughter, nephew, etc. It is important to accurately identify the relationship because this information is used by the Single Point of Entry (and Medi-Cal and the Healthy Families Programs) to determine family size and financial responsibility.
- Leave blank for an unborn child (column 1)

21. Sex

- Indicate the sex of the child
- Leave blank for an unborn child (column 1)

22. Date of Birth

- Enter the birthdate of each child and/or pregnant woman as shown: Month/Day/Year
- If applying for an unborn child (column 1), enter the expected due date

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23. Place of Birth

- Enter the county if the child and/or pregnant woman were born in California
- Enter the state if the child and/or pregnant woman were born in the U.S. but outside California
- Enter the country if the child and/or pregnant woman were born outside the U.S.
- Leave blank for an unborn child (column 1)

24. Ethnic Code

- Indicate the ethnic code of each child and/or pregnant woman. Providing an ethnic code is optional unless the child is American Indian or Alaska Native. The codes are listed on page 3 of the application instructions.

  NOTE: American Indians and Alaska Natives must indicate their ethnic codes. A cost sharing waiver for premium payments and co-payments is available for Healthy Families to American Indians and Alaska Natives.

25. U.S. Citizen or National

- Indicate if the child and/or pregnant woman are U.S. Citizens or Nationals. U.S. Citizens and Nationals include those individuals who were/are:
  - Born in the U.S.
  - Native Americans born in Canada
  - Born in Puerto Rico
  - Born in the Northern Mariana Islands
  - Born in Guam
  - Born in the Virgin Islands of the U.S. (St. Thomas, St. John, and St. Croix)
  - Born in Swain's Island
  - Naturalized citizens
  - Acquired citizenship or derived citizenship
  - Born in American Samoa

- If the "no" box is checked, enter the date of entry into the U.S. See Chapter 6 (*Medi-Cal Program*) and Chapter 7 (*Healthy Families Program*) for more information about the different types of immigration statuses and confidentiality.
- Leave blank for an unborn child (column 1)

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26. Social Security Number

- Enter the Social Security number of each child and/or pregnant woman when applying for Medi-Cal. If the applicant does not provide Social Security numbers when he/she completes the application, the application will still be forwarded to the county Department of Social Services. The county Department of Social Services will contact the applicant for the child's and/or pregnant woman's Social Security numbers.

  NOTE: Social Security numbers are not required by the Healthy Families Program.

Application Page A2

Page A2 of the application obtains information about the children and/or pregnant woman who wants to be enrolled in Medi-Cal or Healthy Families, as well as other family members living in the home.

SECTION 2: Information About Children and Pregnant Woman (Continued)

SECTION 2: Continued	Child 1 or Unborn (Check box ☐ if unborn)	Child 2	Child 3	Child 4	Pregnant Woman
27 Mother's Name: Last					
First					
Does the mother live in the home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
28 Father's Name: Last					
First					
Does the father live in the home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
29 Name of teen's spouse or pregnant woman's husband: *(If living in the home)*					
30 Does any person(s) being applied for have no-cost Medi-Cal? If "yes", give date coverage ends/ended.	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR
31 Does the pregnant woman and/or children have other health, dental or vision insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
32 Were any of the children insured by an employer in the last 90 days? If "yes", check the main reason why health insurance stopped and give the date it stopped.	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other / / MO DAY YR	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other / / MO DAY YR	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other / / MO DAY YR	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other / / MO DAY YR	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other / / MO DAY YR

Section 2: Questions

27. Mother's Name

- List the natural or adoptive mother for each child
- DO NOT list a child's stepmother
- Leave blank for a pregnant woman who is over 19 years old
- Indicate if the mother lives in the home

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28. Father's Name

- List the natural or adoptive father for each child
- DO NOT list a child's stepfather
- Leave blank for a pregnant woman who is over 19 years old
- Indicate if the father lives in the home

29. Teen's Spouse or Pregnant Woman's Husband

- List the name of the teen's spouse if he/she lives in the home
- List the name of the pregnant woman's husband if he lives in the home
- Leave blank if the teen or pregnant woman is not married to her partner
- Leave blank for an unborn child (column 1)

30. No-Cost Medi-Cal

- Indicate if each child and/or pregnant woman is currently receiving no-cost Medi-Cal
- If yes, enter the date no-cost Medi-Cal will end
- Leave blank for an unborn child (column 1)

  NOTE: Applicants can apply up to three months before a child's no-cost Medi-Cal coverage will end.

  REMINDER: Children who receive no-cost Medi-Cal, including Accelerated Enrollment, are not eligible for Healthy Families. Children who receive Share-of-Cost Medi-Cal may be eligible for Healthy Families.

31. Other Health, Dental, or Vision Insurance

- Indicate if the child and/or pregnant woman have other health, dental, or vision insurance
- Example: If the parents have employer-sponsored coverage and the children are uninsured, the answer would be "no."
- Leave blank for an unborn child (column 1)

  NOTE: Children and pregnant women can have other health insurance and still be eligible for no-cost Medi-Cal.

  REMINDER: Children covered by employer-sponsored health coverage are not eligible for Healthy Families coverage.

Application Page A2

32. Employer-Sponsored Insurance

- Indicate if the child was insured by employer-sponsored health coverage in the last 3 months.
- If “yes,” check the box next to the reason coverage ended, and write the date the insurance ended
- See Chapter 7 (*Healthy Families Program*) for more information
- Leave blank for an unborn child (column 1)

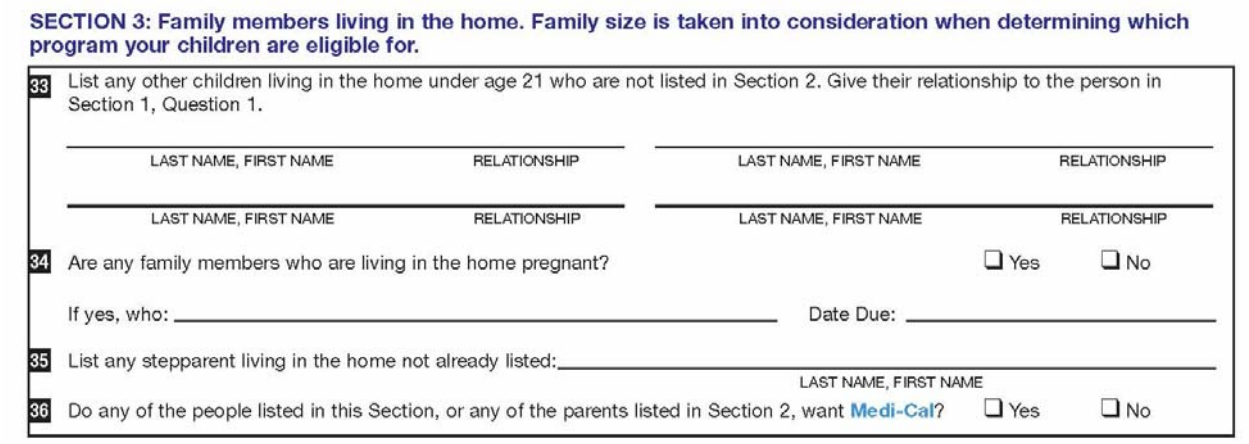
REMINDER: Children who were insured through employer-sponsored health coverage in the last 3 months are not eligible for the Healthy Families Program. The waiting period will be waived if any one of the following occurs to the person through whom the employer-sponsored insurance for the children had been available:

- Loses his or her job
- Moves to a zip code area or region that is not covered by the employer-sponsored coverage
- Loses health benefits because his or her employer stopped health benefits for all employees
- Dies
- Divorces or is legally separated from the parent with whom the child lives

Application Page A2

SECTION 3: Other Family Members in the Home

This section asks for information about other family members who are not already listed in Sections 1 or 2. This information is needed to accurately determine the family size and program eligibility.



SECTION 3: Family members living in the home. Family size is taken into consideration when determining which program your children are eligible for.

33 List any other children living in the home under age 21 who are not listed in Section 2. Give their relationship to the person in Section 1, Question 1.

LAST NAME, FIRST NAME — RELATIONSHIP | LAST NAME, FIRST NAME — RELATIONSHIP

LAST NAME, FIRST NAME — RELATIONSHIP | LAST NAME, FIRST NAME — RELATIONSHIP

34 Are any family members who are living in the home pregnant? ❑ Yes ❑ No

If yes, who: _____ Date Due: _____

35 List any stepparent living in the home not already listed: _____
LAST NAME, FIRST NAME

36 Do any of the people listed in this Section, or any of the parents listed in Section 2, want Medi-Cal? ❑ Yes ❑ No

Section 3: Questions

33. Other Children Living in the Home Under Age 21

- List any children under age 21 living in the home NOT listed in Section 2. These children typically include:
  - Children who already have health coverage
  - Children ages 19 to 21
  - Children who meet BOTH of the following requirements:
    - Away at school
    - Claimed as tax dependents by their parents

- DO NOT list children who receive SSI/SSP or public assistance. They are not counted in the family size. See Chapter 4 (*Family Size and Income Determination*) for more information.

Application Page A2

Section 3: Questions

34. Pregnant Family Members

- List any family members who are pregnant. This could be a pregnant teen, parent, or stepparent living in the home. This information is required because the unborn child is counted in the family size.

  If pregnant women or teens wish to apply for Medi-Cal, they should mark “yes” on Question 36. Women who are late-term or have a high-risk pregnancy should apply directly at their local county Department of Social Services for a faster eligibility determination.

35. Stepparent in the Home

- List any stepparents living in the home who are not already listed on the application in Section 1 or Section 2
- List only the stepparents. DO NOT list any live-in partners.

36. Other Family Members Who Want Medi-Cal

- Indicate if any of the family members in this section want Medi-Cal
- The family will be contacted by the local county Department of Social Services to obtain additional information required to determine if these family members qualify for Medi-Cal

  NOTE: If the applicant indicates not wanting Medi-Cal (Question 16), the application WILL NOT be forwarded to the county Department of Social Services for a Medi-Cal eligibility determination.

Application Page A3

Page A3 of the application obtains information about family members' different sources of income, as well as the deductions for which they may be eligible. It also asks if families want to apply for retroactive Medi-Cal and includes a certification that the information provided is true and correct.

SECTION 4: Income Information

The information in this section is used to determine the gross income, source of income and how often the income is received for each family member.

SECTION 4: List the gross income (before taxes) of all persons listed in Section 2, Questions 17, 27, 28, 29 and Section 3 who live in the home. If self-employed or using federal income tax return to prove income, only complete Questions 37, 38 and 40 in this section.

37 NAME OF PERSON WITH INCOME	38 SOURCE OF INCOME?	39 HOW OFTEN RECEIVED?	40 HOW MUCH GROSS INCOME?	41 SOCIAL SECURITY # *(Optional)*
1.				
2.				
3.				
4.				

Section 4: Questions

37. Name of Person With Income

- List the name of each family member with income
- Use a separate line for each source of income

REMINDER: Child support received is the CHILD'S income and must be listed with the CHILD'S NAME and NOT the parent's name. DO NOT list the income of people in the home who are not counted in the family size.

Application Page A3

38. Source of Income

- List where the income comes from, such as work (give name of the employer, self-employment), Social Security, or child support. See Chapter 4 *(Family Size and Income Determination)* for more information.

  REMINDER: Do not list income that is not counted. See Chapter 4 *(Family Size and Income Determination)* for more information.

  NOTE: Public assistance, such as SSI/SSP, CalWORKs and General Relief, which results in the recipients NOT COUNTED in the family size must be listed as income and proof must be submitted. This income will not be counted but is needed by SPE to make sure these individuals are not counted in the family size. See Chapter 4 (*Family Size and Income Determination*) for more information.

39. How Often Received

- List how often the income is received (for the amount reported in gross income):
  - Weekly (paid once a week)
  - Every two weeks (paid every other week)
  - Twice a month (paid two times a month, e.g., the 15th and 30th)
  - Monthly (paid once per month)

40. Gross Income

- List the gross income amount on the paycheck stub or other proof of income (before taxes or other withholdings)
- List the gross amount on the pay stub. For example, if family members are paid weekly, list the amounts they are paid each week and NOT the calculated monthly incomes.

  NOTE: If family members are self-employed or using federal income tax returns to prove their incomes, complete questions 37, 38 and 40. Leave question 39 blank. See Chapter 4 (*Family Size and Income Determination*) for more information.

41. Social Security Number

- Enter the Social Security numbers of the family members with incomes
- This information is OPTIONAL for both Medi-Cal and Healthy Families Programs

Application Page A3

SECTION 5: Income Deductions

This section asks for information to determine the appropriate income deductions. Some deductions, such as the $90 work expense deduction and the $50 deduction for receiving child support or alimony, are not listed in this section. These deductions are given automatically based on the proof of income included with the application.

> This section is divided into two parts:
>
> - Child support and alimony paid
> - Child care or dependent care expenses
>
> If families do not make these payments, leave blank.

SECTION 5: Deductions from Family Income. The answers in this section will help determine what amounts will be deducted from your family's gross monthly income.

42 TYPE OF PAYMENT YOUR FAMILY MAKES	43 NAME OF PERSON WHO PAYS	44 MONTHLY AMOUNT PAID
Child Support		
Alimony		

45 CHILD CARE OR DEPENDENT CARE *(List child's name)*	46 AGE	47 MONTHLY AMOUNT PAID
1.		
2.		
3.		
4.		

Questions 42-44 Child Support and/or Alimony Payments

42. Type of Payment Your Family Makes

- List any court-ordered child support and/or alimony paid

43. Name of Person Who Pays

- List the names of the family members who pay court-ordered child support and/or alimony

44. Monthly Amount Paid

- List the court-ordered amount or the actual amount paid per month, whichever is less

  NOTE: Only COURT-ORDERED payments can be deducted.

Application Page A3

Questions 45-47 Child Care and Dependent Care Expenses

45. Child Care or Dependent Care

- List the names of the children or dependents who are receiving child or dependent care

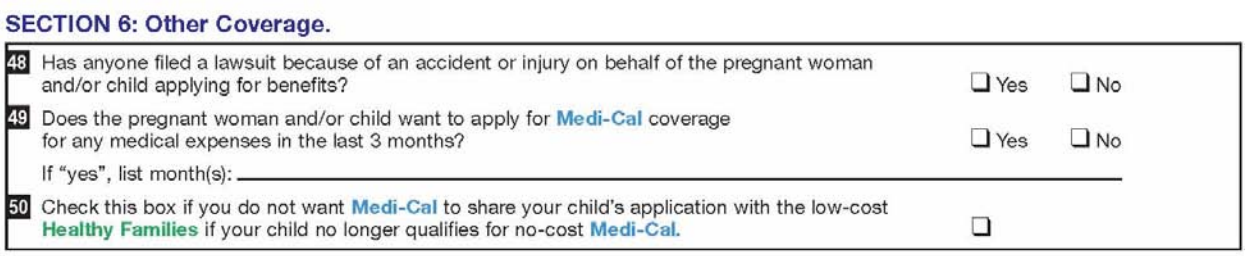
46. Age

- List the ages of the children and dependents

47. Monthly Amount Paid

- List total amount PAID PER MONTH for child/dependent care, even if it is more than the maximum deductions allowed
- The maximum deduction depends on the age of each child:
  - Up to $200 per child under 2 years of age
  - Up to $175 per child age 2 and older
  - Up to $175 per disabled dependent

SECTION 6: Other Coverage



SECTION 6: Other Coverage.

48	Has anyone filed a lawsuit because of an accident or injury on behalf of the pregnant woman and/or child applying for benefits?	❑ Yes	❑ No
49	Does the pregnant woman and/or child want to apply for Medi-Cal coverage for any medical expenses in the last 3 months?	❑ Yes	❑ No
	If "yes", list month(s): _____		
50	Check this box if you do not want Medi-Cal to share your child's application with the low-cost Healthy Families if your child no longer qualifies for no-cost Medi-Cal.	❑	

Section 6: Questions

48. Lawsuit on Behalf of the Child or Pregnant Woman

- Indicate "yes" or "no" if a lawsuit has been filed because of an accident or injury caused by another person or while at work. Medi-Cal will cover the services needed because of the accident.

If the person used Medi-Cal for treatment and then received an insurance or other type of settlement, he/she must repay the cost of the Medi-Cal services received for treatment because of the accident or injury. Only the costs of services for treatment related to the accident or injury must be repaid. If the settlement the family receives is less than the cost of services Medi-Cal provided, the family will have to repay only the amount of the settlement.

Application Page A3

- **NOTE:** The family does not pay Medi-Cal if the person does not receive a settlement.

49. Medi-Cal Coverage for Previous Medical Expenses

    - Indicate “yes” or “no” if the children and/or pregnant woman want to apply for Medi-Cal for past medical expenses.

      Medi-Cal can pay for past medical bills if the applicants or children have medical expenses during the 3 months before the date of application (when the application is received at SPE). This is called retroactive Medi-Cal. See Chapter 6 *(Medi-Cal Program*) for more information.

      When the county Department of Social Services receives the applications, it will contact the applicants to obtain the information needed for the month(s) coverage is requested.

      NOTE: Children who are eligible for Healthy Families may be eligible for assistance from Medi-Cal with past medical expenses.

    REMINDER: To receive this coverage, Question 16, “I DO NOT WANT: Medi-Cal” box must NOT be checked.

    NOTE: If it is close to the end of the month and families are requesting retroactive Medi-Cal for the earliest month possible, it is best for the applicant to go the county Department of Social Services to complete the application for retroactive (past) medical expenses instead of using the mail-in application. See Chapter 6 (*Medi-Cal Program)* for more information and an example.

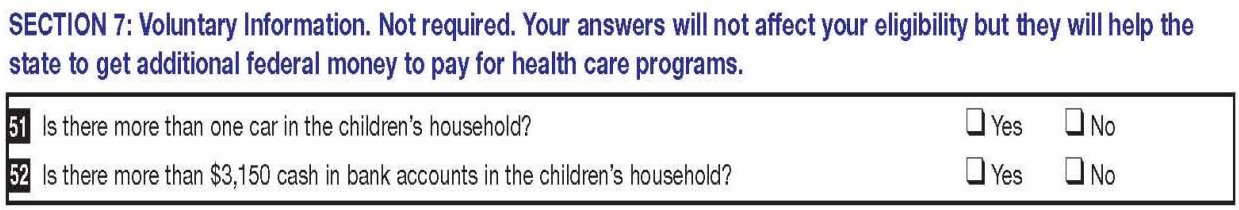
50. Check this box if you do not want Medi-Cal to share your child’s application with the low-cost Healthy Families Program if your child no longer qualifies for no-cost Medi-Cal.

Application Page A3

SECTION 7: Voluntary Information

This information is VOLUNTARY and DOES NOT affect families' eligibility for the Healthy Families Program, but Medi-Cal needs this information for Medi-Cal eligibility determination. The applicant only needs to indicate "yes" or "no."

Answers to these two questions may help the State of California claim federal funds for its health care programs.


SECTION 7: Voluntary Information. Not required. Your answers will not affect your eligibility but they will help the state to get additional federal money to pay for health care programs.

51	Is there more than one car in the children's household?	❑ Yes	❑ No
52	Is there more than $3,150 cash in bank accounts in the children's household?	❑ Yes	❑ No

Section 7: Questions

51. More Than One Car

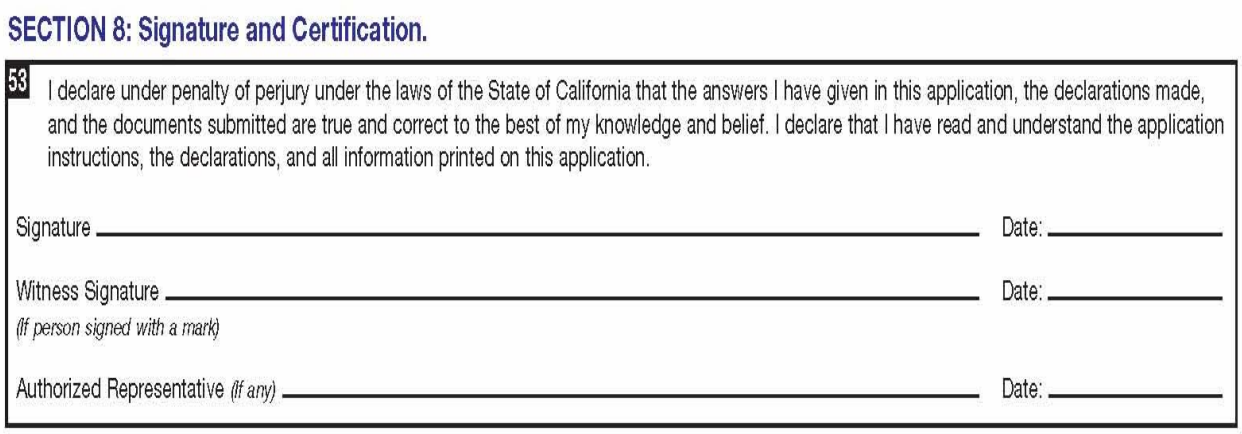
- Indicate "yes" or "no" whether there is more than one car in the child and/or pregnant woman's household

52. More than $3,150 Cash in Bank Accounts

- Indicate "yes" or "no" whether there is more than $3,150 cash in bank accounts in the children or pregnant woman's household

Application Page A3

SECTION 8: Signature and Certification



SECTION 8: Signature and Certification.

53 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature _____ Date: _____

Witness Signature _____ Date: _____
(If person signed with a mark)

Authorized Representative *(If any)* _____ Date: _____

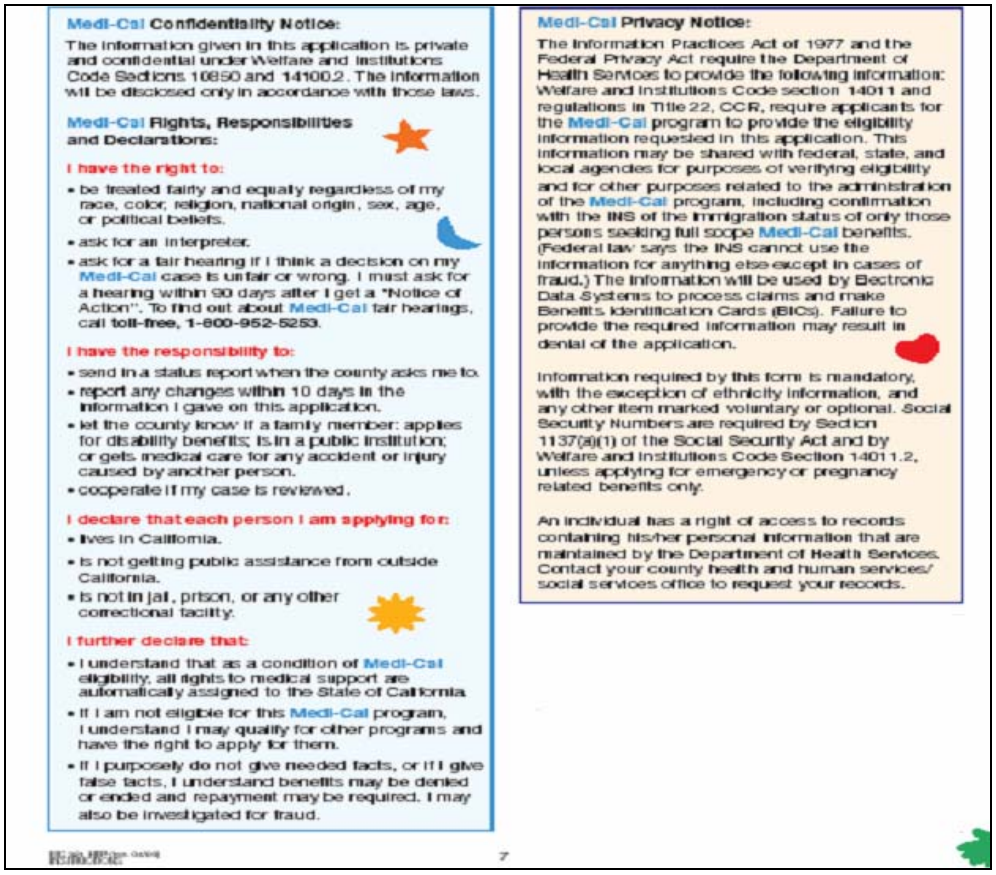
Section 8: Questions

53. Signatures

- The applicant is required to sign and date the application on the signature line
- CAAs must explain to the applicant that by signing "under penalty of perjury" he/she can be prosecuted for information that is knowingly misrepresented on the application
- The signature of a witness is necessary if the applicant signs with a mark, such as an "X"
- An Authorized Representative is someone who can sign on behalf of the applicant. No proof is required to be submitted with the application to show that the person is the Authorized Representative. The county Department of Social Services and Healthy Families will contact the applicant if additional information is required.

Application Page A3

Medi-Cal Rights, Responsibilities and Declarations:



Medi-Cal Confidentiality Notice:

Medi-Cal Confidentiality Notice:

The information given in this application is private and confidential under Welfare and Institutions Code Sections 10850 and 14100.2. The information will be disclosed only in accordance with those laws.

Medi-Cal Rights, Responsibilities and Declarations:

I have the right to:

- be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- ask for an interpreter.
- ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.

I have the responsibility to:

- send in a status report when the county asks me to.
- report any changes within 10 days in the information I gave on this application.
- let the county know if a family member: applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- cooperate if my case is reviewed.

I declare that each person I am applying for:

- lives in California.
- is not getting public assistance from outside California.
- is not in jail, prison, or any other correctional facility.

I further declare that:

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal program, I understand I may qualify for other programs and have the right to apply for them.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

Medi-Cal Privacy Notice:

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application. This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except in cases of fraud.) The information will be used by Electronic Data Systems to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1137(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services. Contact your county health and human services/ social services office to request your records.

7

Medi-Cal Confidentiality Notice:

- Information given on the application is private and confidential under Welfare and Institutions Code Sections 10850 and 141002. The information will be disclosed only in accordance with those laws.

Medi-Cal Rights, Responsibilities and Declarations:

- I have the right to:
  - be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
  - ask for an interpreter.
  - ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.

Application Page A3

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  - send in a status report when the county asks me to.
  - report any changes within 10 days in the information I gave on this application.
  - let the county know if a family member: applies for disability benefits; is in a public institution: or gets medical care for any accident or injury caused by another person.
  - cooperate if my case is reviewed.

- I declare that each person I am applying for:
  - lives in California.
  - is not getting public assistance from outside California.
  - is not in jail, prison, or any other correctional facility.

- I further declare that :
  - I understand that as a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
  - if I am not eligible for this Medi-Cal program, I understand I may qualify for other programs and have the right to apply for them.
  - if I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

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- Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1137(a) (1) of the Social Security Act and by Welfare and Institiutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.
- An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services. Contact your county health and human services/social services office to request your records.

Application Page A3

Section 9: Reimbursement for Application Assistant Use Only

Section 9 must be complete at the time of initial application submission in order for reimbursements for CAA assistance to be processed.

SECTION 9: Fill in ONLY if you have been helped by a Certified Application Assistant (CAA).

54 If you would like information released to a CAA, check this box:

☐ By checking this box and signing below, I give my permission for Healthy Families and Medi-Cal to give information over the telephone about the status of this Application to the representative of the Enrollment Entity organization identified below. This permission will end on the date the program mails the results of the eligibility determination on this Application.

55 I certify I had help completing this form by the Certified Application Assistant listed below. This CAA help was **FREE** of charge. CAA#: ☐☐☐☐☐☐☐☐☐ EE#: ☐☐☐☐☐

Applicant Signature: _____ Date: _____

CAA Signature: _____ Date: _____

The state will not issue a reimbursement to the enrollment entity unless this question is completely and correctly filled out at the time this Application Form is submitted.

Section 9: Questions

54. Authorization for Application status

- By checking this box the Enrollment Entity will have the authority to get application status information for the applicant. Once eligibility is determined this permission ends.

55. Applicant and CAA Signatures

- The applicant signs and dates the application to verify that he/she was assisted by a Certified Application Assistant
- The CAA also signs and dates the application and enters his/her CAA# and EE#

  NOTE: The nine-digit CAA number and five digit EE number are needed to track applications where the applicant was assisted by the CAAs and their EEs. See Chapter 3 (*Healthy Families and Medi-Cal Mail-In Application*).

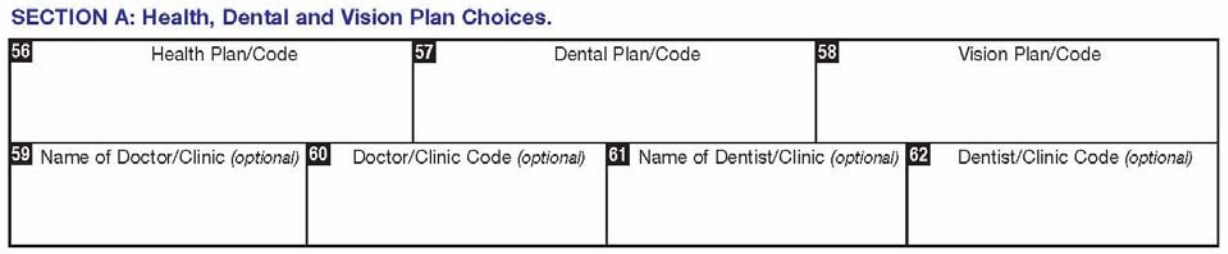
Application Page A4

Page A4 of the application pertains to the Healthy Families Program only. Information about the available health, dental, and vision plans and providers is listed in the Healthy Families Handbook and on the Healthy Families website, www.healthyfamilies.ca.gov.

If the applicant does not select health, dental, and vision plans for the children who are eligible for Healthy Families, he/she will be contacted to select plans. If the applicant does not respond with plan selections the Healthy Families Program will automatically assign plans for the eligible child(ren). See Chapter 7 (*Healthy Families Program*) for more information.

The family is not required to select providers (doctor, dentist or clinic) for the children who are eligible for Healthy Families when submitting the application. If the family does not select providers, however, the plans will assign the providers. See Chapter 7 (*Healthy Families Program)* for more information.

SECTION A: Health, Dental, and Vision Plan Choices


SECTION A: Health, Dental and Vision Plan Choices.

56 Health Plan/Code	57 Dental Plan/Code	58 Vision Plan/Code

59 Name of Doctor/Clinic *(optional)*	60 Doctor/Clinic Code *(optional)*	61 Name of Dentist/Clinic *(optional)*	62 Dentist/Clinic Code *(optional)*

Questions A: Health, Dental, and Vision Plan Selection

56. Health Plan/Code

- List the health plan name AND code number for the plan the family has selected

57. Dental Plan/Code

- List the dental plan name AND code number for the plan the family has selected

58. Vision Plan/Code

- List the vision plan name AND code number for the plan the family has selected

Application Page A4

SECTION A: Health, Dental and Vision Plan Choices.

56 Health Plan/Code	57 Dental Plan/Code	58 Vision Plan/Code

59 Name of Doctor/Clinic *(optional)*	60 Doctor/Clinic Code *(optional)*	61 Name of Dentist/Clinic *(optional)*	62 Dentist/Clinic Code *(optional)*

Questions A: Provider Selection

If the applicant has chosen a doctor or clinic for the child, list the provider information here.

59. List the name of the doctor or clinic the applicant has chosen for the child(ren).

60. List the code for the doctor or clinic applicant has chosen for the child(ren).

61. List the name of the dentist or clinic applicant has chosen for the child(ren).

62. List the code for the dentist or clinic applicant has chosen for the child(ren).

SECTION B: Special Population Plan (Formerly the Rural Demonstration Project)

This is an optional plan available to American Indians, Alaska Natives, and families working in seasonal or migratory jobs in agriculture, forestry, or fishing. Families who qualify for the Special Population Plan are not required to select it. They may select any of the plans available in their county. The advantage of the Special Population Plan is that it is available statewide, and families will not need to change their children's plans when they move from county to county.

The plan information is listed in the Healthy Families Handbook, including the plan combination code and premium information.

NOTE: Families should make sure they notify Healthy Families whenever their addresses change to ensure that they receive all premium bills and program notices.

SECTION B: Rural Demonstration Project. (Now known as Special Population Plan)

63 If you are in any of these groups, there is a new statewide health, dental and vision plan combination offered to you. You can pick this new combination and put the code in the box below. See the Healthy Families Handbook for the combination code number.

Check all boxes that apply to you.

❑ Native American Indian **OR** Working in seasonal or migratory jobs: ❑ Agriculture ❑ Forestry ❑ Fishing

Plan Combination Code

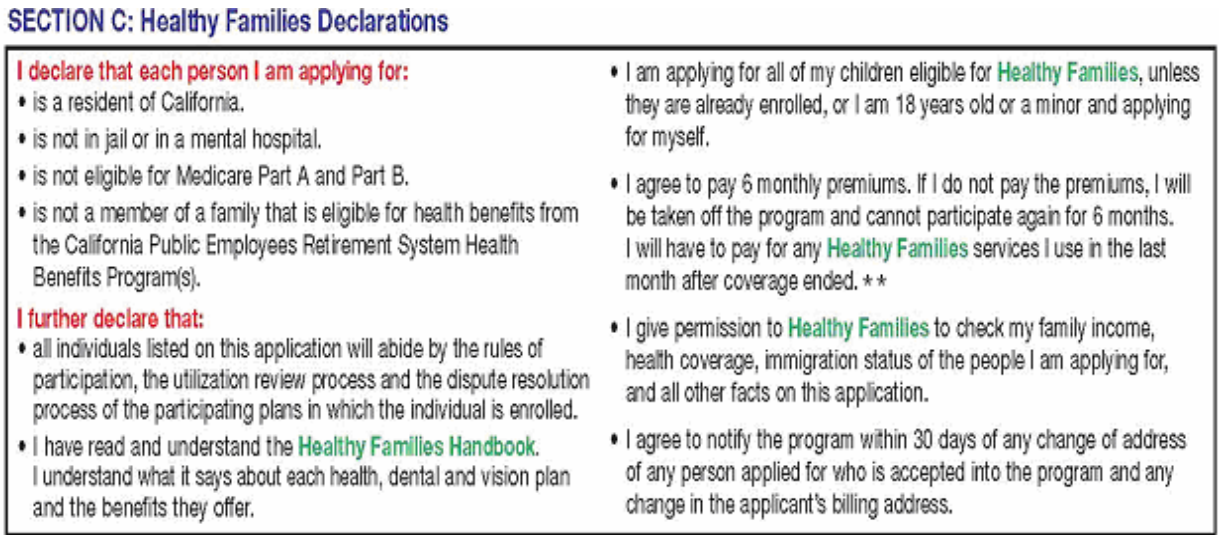
Application Page A4

Section B: Questions

63. Special Population Plan

- If the applicant chooses the Special Population Plan (formerly known as Rural Demonstration Project), indicate if the applicant is any of the following:
  - American Indian or Alaska Native
  - Working in a seasonal or migratory job in agriculture
  - Working in a seasonal or migratory job in forestry
  - Working in a seasonal or migratory job in fishing
- Plan Combination Code Box: Enter the Plan Combination Code for the Special Population Plan. This information is listed at the end of the Insurance Plans by County and Premium section of the Healthy Families Handbook.

SECTION C: Healthy Families Declarations



SECTION C: Healthy Families Declarations

I declare that each person I am applying for:
- is a resident of California.
- is not in jail or in a mental hospital.
- is not eligible for Medicare Part A and Part B.
- is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s).

I further declare that:
- all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating plans in which the individual is enrolled.
- I have read and understand the Healthy Families Handbook. I understand what it says about each health, dental and vision plan and the benefits they offer.
- I am applying for all of my children eligible for Healthy Families, unless they are already enrolled, or I am 18 years old or a minor and applying for myself.
- I agree to pay 6 monthly premiums. If I do not pay the premiums, I will be taken off the program and cannot participate again for 6 months. I will have to pay for any Healthy Families services I use in the last month after coverage ended. **
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this application.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

****NOTE**: Children will be taken off of the program when premiums are 2 months past due. There is no 6-month waiting period to re-apply. Applicants must pay any past due premiums that they owe when they re-apply.

The Certified Application Assistant should review with the applicant the Healthy Families Declarations listed in this section.

Application Page A4

The applicant is required to make the following declarations listed below.

The applicant declares that each person he/she is applying for:

- Is a resident of California
  Children must be California residents to be eligible for Healthy Families.
- Is not in jail or in a mental hospital.
- Is not eligible for Medicare Part A and Part B.
  Children eligible for Medicare Part A and Part B are not eligible for Healthy Families.
- Is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s) (CALPERS)
  - Children eligible for health benefits from CALPERS are not eligible for Healthy Families unless CALPERS pays less than $10 a month towards the children's benefits
  - Examples of employees who may be eligible for CALPERS are federal, state, or county employees, as well as school district employees

The applicant further declares that:

- All individuals listed on this application will abide by the rules of participation, the utilization review process and dispute resolution process of the participating plans in which the individual is enrolled.
- I have read and understand the Healthy Families Handbook. I understand what it says about each health, dental, and vision plan and the benefits they offer.

  The handbook contains important information about eligibility, premiums, and other program details.

- I am applying for all of my children eligible for Healthy Families, unless they are already enrolled, or I am 18 years old or a minor and applying for myself.
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this application.
- I agree to notify the program within 30 days of any changes of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

  Healthy Families must have the applicant's up-to-date address to mail the monthly bill for the premium, as well as other important program information including the Annual Eligibility Review forms.

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SECTION D: Privacy Notice

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The Information Practices Act of 1977 and the Federal Privacy Act require the **Healthy Families** Program to provide the following notice to individuals who are asked by **Healthy Families** to supply information:
Personal and medical information requested is for subscriber identification and program administration purposes only. Program regulations under Title 10, CCR, Section 2699.6600 require that every individual furnish certain information when applying to the **Healthy Families** Program. Subscriber's information may be shared with State and local agencies involved in the administration of health programs. Information (including immigration status) about persons who do not become subscribers, will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.
The following information on the application is not mandatory: social security number, ethnicity information (unless the subscriber is a Native American Indian) and any other item marked voluntary or optional. An individual has a right to access records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is the Deputy Director of Eligibility and Enrollment, Managed Risk Medical Insurance Board, 1000 G Street, Room 450, Sacramento, California 95814, (916) 324-4695.

The information in this section explains how the application information provided by the applicant will be used by the Healthy Families Program.

CAAs must review this section with the applicant.

SECTION E: Resolving Disputes

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If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. The **Healthy Families Handbook** has information about each plan and the arbitration requirements. You may call the plans you choose to find out more.

Many of the plans families choose for their children's Healthy Families coverage, require that all disagreements (coverage disputes, denials of service, and medical malpractice claims) be sent to Binding Arbitration. Other plans allow patients to file a court action for medical malpractice, but require other types of disagreements to be arbitrated. Arbitration is an out-of-court process for settling disagreements.

The Healthy Families Handbook lists which plans require Binding Arbitration in the “Answers to Commonly Asked Questions” section.

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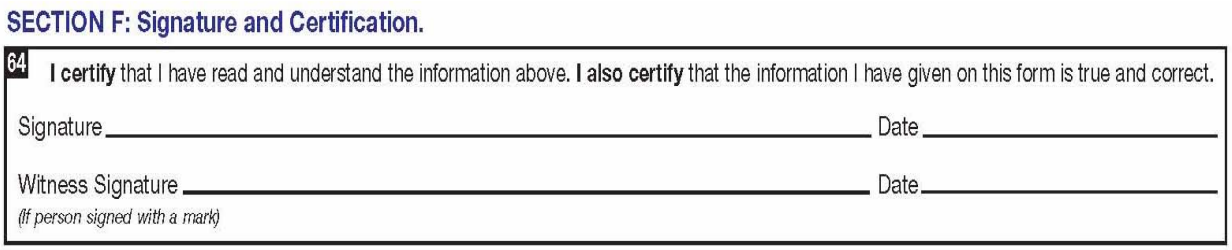
SECTION F: Signature



SECTION F: Signature and Certification.

64 **I certify** that I have read and understand the information above. **I also certify** that the information I have given on this form is true and correct.

Signature _____ Date _____

Witness Signature _____ Date _____

(If person signed with a mark)

Section F: Questions

64**.** Signatures

- The applicant is required to sign and date his/her application on the signature line
- CAAs must explain to the applicant that he/she is certifying that the information is true and correct and that he/she can be prosecuted for information that is knowingly misrepresented on the application
- The signature of a witness is necessary if the applicant signs with a mark, such as an “X”